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THE AUSTRALIAN COUNCIL ON HEALTHCARE STANDARDS
ACHS
Safety Quality Performance

The Australian Council on Healthcare Standards

Submission to the Australian Commission on Safety and Quality in Health Care

Clinical Care Standard Consultation Draft

- ↘ Acute Coronary Syndrome
- ↘ Antimicrobial Stewardship

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Introduction

On behalf of the Board and Council of ACHS, appreciation is expressed for the continuing extensive consultations for the development of resources to support safe, quality healthcare. Appreciation is also expressed to the Australian Healthcare and Hospitals Association (AHHA) and in particular to the Chief Executive of AHHA Alison Verhoeven for this contribution to this submission.

The following comments are provided with assistance from ACHS surveyors with expertise in the areas of acute coronary syndrome and antimicrobial stewardship. The comments are made in relation to the questions of particular interest in the consultation documents:

A. Consultation Draft: Clinical Care Standard for Acute Coronary Syndrome

B. Consultation Draft: Clinical Care Standard for Antimicrobial Stewardship

A. Response to Acute Coronary Syndrome Clinical Care Standard Consultation Draft

1. **How well does each quality statement cover the key aspects of care that it describes? Please provide any comments you may have, and evidence to support any modification to a quality statement.**

ACHS makes the following suggestions for changes to the quality statements:

Quality Statement 3 – Immediate management

- The health services quality statement meaning should have the additional words 'and competent' following 'clinicians are trained...', as there is an expectation of competency practice and ongoing competency assessment.

Quality statement 5 – Coronary angiography

- In the Clinician's quality statement meaning, (2nd dot point) include 'carer' as well as the patient within the discussion forum to reinforce the partnership requirement.
- In the health services quality statement meaning, the descriptor is obscure and requires clarification. 'The systems, processes and infrastructure are in place to support and ensure a relevant discussion has taken place and that the patient has provided informed consent prior to the medical procedure'. The author should also consider differences in infrastructure and patient requirements in different clinical settings such as large hospitals or specialty private hospitals.

Quality statement 6 – Individualised care plan

- The opening statement needs to consider the patient's carer when developing the individualised care plan.

- In the health services quality statement, (3rd dot point), patient discharge summaries are generally not an issue for private hospitals; however, on occasion there can be resistance by staff. It is recommended that time limitations should be prescribed for discharge summaries to reach a patients GP (for example, 7 days after discharge) as acute conditions would warrant prompt expedient follow-ups.

2. What factors currently prevent the care described in the Clinical Care Standard from being achieved?

- Recognition of the differences between public and private practices is a factor that may prevent the care described in the Clinical Care Standard for Acute Coronary Syndrome from being achieved.

3. What factors will support the practical application of this Clinical Care Standard?

- The Clinical Care Standard for Acute Coronary Syndrome could be included in the Guidelines and Workbook for NSQHS Standard 1, item 1.7, regarding developing and applying evidence-based clinical guidelines or pathways.

4. How relevant are the suggested indicators in supporting the monitoring of the quality statements at the local health service level? Please provide any comments you may have, and evidence to support any modifications.

- ACHS offers the following comments on the suggested indicators for the Clinical Care Standard for Acute Coronary Syndrome

Quality statement 1 – Early assessment (CCS.ACS.1a)

- There could be limitations for ambulance services to provide data to health services. The quality of the ambulance data could vary between volunteer/professional and country/city ambulance services.

Quality statement 4 – Risk stratification (CCS.ACS.4b)

- Replace the term “referred” with “transferred”

5. How should the Clinical Care Standard be disseminated (e.g. web based resources, printed resources, etc.)?

- The surveyor workforce is now conditioned to regularly visit the ACSQHC’s website for updates and advisories. Web-based resources are preferred.
- A link to the accreditation workbook may be useful as this standard has strong links to actions 1.7.1 and 1.7.2.

6. Do you have any general comments in relation to each Clinical Care Standard?

- ACHS has no further comments on the Clinical Care Standard for Acute Coronary Syndrome

B. Response to Antimicrobial Stewardship Clinical Care Standard Consultation Draft

1. **How well does each quality statement cover the key aspects of care that it describes? Please provide any comments you may have, and evidence to support any modification to a quality statement.**

Quality statement 3 – information on treatment options

- Clinician's Quality statement, (2nd dot point), patient preferences and needs should not only be discussed, they should also be referenced in the medication management plan.

Quality statement 5 – taking antibiotic as prescribed

- Clinician's Quality statement, (2nd dot point) should also include documentation in the medication management plan of the results of any discussion.

Quality statement 6 – documentation

- Clinician's Quality statement, (2nd dot point): NSQHS Standard 4 references a medication management plan; medication chart documentation should also support effective clinical handover (ref NSQHS Standard 6) especially if there has been a change to the type and quantity of drug being prescribed.
- Health services statement, (3rd dot point) needs to mention documentation and handover of information.

Quality statement 7 – Use of broad-spectrum antibiotics

- Clinician's Quality statement, (2nd dot point) should include that any changes are to be documented in the medication management plan and/or medication chart and should be discussed at clinical handover.
- Health services statement, (3rd dot point), the system used must be capable of documenting any changes and the reasons for the change.

Quality statement 8 – Review of treatment

- Clinician's Quality statement, (2nd dot point), any changes must be documented in the medication management plan and/or the medication chart.

Quality statement 9 – Surgical prophylaxis

- Patient's Quality statement, (1st dot point): the administration of antibiotics intravenously post-surgery during day surgery needs to be considered, and to ensure there are systems to monitor and report on usage.

2. **What factors currently prevent the care described in the Clinical Care Standard from being achieved?**

- Private hospitals will have difficulty implementing many of the quality measures suggested by the clinical care standard based on the lack of documentation to facilitate a retrospective audit process.
- There should be recognition of the differences between public and private practices.
- Small day facilities or facilities which have no onsite pharmacist or access to pharmacy or ID physician advice, may have issues with implementation of the Clinical Care Standard for Antimicrobial Stewardship. In addition, many services are struggling with the ability to provide a comprehensive list of medicines and changes to medications.

3. What factors will support the practical application of this Clinical Care Standard?

- Surgical antibiotic prophylaxis compliance is generally captured as part of the organisation's mandatory surgical site infection surveillance program and/or Surgical Safety Checklists.

4. How relevant are the suggested indicators in supporting the monitoring of the quality statements at the local health service level? Please provide any comments you may have, and evidence to support any modifications.

Quality statement 2 – Microbiological testing

- Suggest that a signoff be implemented to indicate the results have been read by the treating clinician.

Quality statement 5 – Taking antibiotics as prescribed

- There could be an indicator to address the need to identify high risk patients and any associated negative incidents since in many cases the taking of antibiotics occurs after the patient is discharged.

Quality statement 6 – Documentation

- Documentation relating to clinical handover should be included.
- CCS.AMS.6a: should include the number of changes and number of incidents associated with non-actioning requested changes as part of the handover procedure.
- Some of the Quality Indicators could be applicable to other NSQHCS Standards, for example:
    i. CCS.AMS.1a could be linked to Standard 9
    ii. CCS.AMS.4b could be linked to Standard 4 & 5
    iii. CCS.AMS.6a/7/8a could be linked to Standard 6
    iv. CCS.AMS.9a/9b could be linked to Standard 5

5. How should the Clinical Care Standard be disseminated (e.g. web based resources, printed resources, etc.)?

- The surveyor workforce is now conditioned to regularly visit the ACSQHC's website for updates and advisories. Web-based resources are preferred.

6. Do you have any general comments in relation to each Clinical Care Standard?

- Agencies approved to assess health service organisations to NSQHS Standard 3 are required to apply Criterion 4 equally to all health services. The scope of the draft Clinical Care Standard for Antimicrobial Stewardship excludes all paediatric services ("This Clinical Care Standard relates to care adults should receive…").
- The goal of the Clinical Care Standard is to ensure the appropriate use and review of antibiotics to optimise patient's outcomes, lessen the risk of adverse effects and reduce the emergence of antibiotic resistance. This goal is also a national priority for paediatrics.
- The draft clinical care standard has applied a quality indicator to dental practices which is inconsistent with NSQHS Standard 3.14.3. This is a non-applicable item for dental practices. However the flip side to this is that there are documented guidelines for the administration of prophylactic antibiotics in some common dental procedures.

Additional commentary:

- The scope should also include clinical care standards for children's treatment with restricted antibiotics.
- It is recommended that the term "antibiotic stewardship" be changed to a more accurate term such as "Antibiotic Usage Standard". This is because the term "stewardship" in the context of governance arrangements relates to antibiotic prescription arrangements and the correlation of prescriptions with local resistance patterns.
- There are some deficiencies in identifying antibiotic prescription patterns in certain community sectors. For example, the prescription of antibiotics in Aged Care Institutions and the governance surrounding the prevention of antibiotic resistance was not addressed.
- Linkages between local microbiology, clinical microbiology or infectious diseases services and the governance surrounding antibiotic resistance prevention strategies in defined community groups, especially those in remote locations, was not addressed.
- It is recommended that hospitals should be directed to develop their own antibiotic resistance prevention stewardship program.
- ACHS has concerns that the antibiotic resistance stewardship standard will not be a high priority for Australian health governance.

End.